# SUMMARY OF BENEFITS

***Your CIGNA Choice Fund℠***
***Health Reimbursement Arrangement-Open Access Plus plan***

CIGNA HealthCare

## Features that Add Value

- **CIGNA Choice Fund** combines conventional health coverage with health funds to help you pay for the cost of your covered healthcare services. See next page for more information.
- The convenience of **referral-free access** to physicians, and the option to select a **personal Primary Care Physician (PCP)** as your source for routine care and guidance when you need specialized care. As your needs change, so may your choice of doctors. That's why you can change your PCP for any reason.
- The CIGNA HealthCare 24-Hour Health Information Line℠ connects you **to registered nurses** and a **library** of hundreds of recorded programs on important health topics 24 hours a day, seven days a week, from anywhere in the U.S.
- **CIGNA Healthy Rewards®** includes special offers on health and wellness programs and services not covered by many traditional benefits plans. Just call 1.800.870.3470 or visit our web site at www.cigna.com.
- Prescription drug coverage is a **part of your plan**. More than 50,000 pharmacies participate nationwide, so you can have your prescription filled **wherever you go**. Mail-order service means quick, **convenient** delivery of your medications right to your home.

## Quality Service Is Part of Quality Care

- **Service** is at the heart of everything we do. Our goal is to give you: fast, accurate answers; responsive, courteous and professional assistance; and ease and convenience in finding the information you need to manage your health.
- **www.cigna.com** – Visit our **interactive Web site** to learn more about your plan and get health information, 24 hours a day. Once you enroll, register for myCIGNA.com, our convenient, secure web site that combines WebMD® tools with personalized benefits information to help you make the most of your plan.
- **We Speak Many Languages℠**. We offer Language Line Services so that you can **talk with us** in 150 different languages. Just call Customer Service and ask for an interpreter to assist you.
- Our interactive voice response system helps you find what you need faster over the phone. Use the speech recognition feature for information on your benefits, level of coverage, claims status, and more.

## It's Your Health

When you choose CIGNA HealthCare, you can take advantage of our **health and wellness** programs

- We encourage you to use a **PCP** as a valuable resource and personal health advocate.
- **Preventive care services** for every covered family member.
- CIGNA Well Aware for Better Health® can **help you manage** certain chronic conditions.
- **CIGNA Healthy Pregnancies, Healthy Babies℠** is designed to help prevent complications during pregnancy and improve the chances for healthy pregnancies and deliveries. The program aims to identify expectant mothers with risk factors, and help them lower their risk of complications with patient education, wellness programs and targeted support from nurse case managers.
- The **CIGNA Comprehensive Oncology Program℠** promotes cancer prevention and early detection through personalized care management, educational tools, benefit counseling, and other resources.

## You Can Depend on CIGNA HealthCare

- **Quality comes first**. We select participating providers carefully. And we make sure you have a **wide range** of doctors to choose from.
- **Emergency and urgent care are covered** wherever you go, worldwide, **24 hours a day**. Urgent care centers can take care of your urgent care needs, and your cost is lower.

## It's Your Choice

- When you visit network providers, you get access to quality care and lower out-of-pocket costs. Your plan also offers the **freedom to choose** the providers you prefer — even if they aren't part of the network. Your benefits are higher when you see "participating providers," but you're still covered for visits to other providers. Participating providers charge a discounted rate for CIGNA members. If you use a non-network provider, the provider may bill you for the difference between the billed charge and the allowed amount under your benefit plan, in addition to applicable (higher than in-network) deductibles and coinsurance amounts.

## For Pensioners of Metropolitan Government of Nashville and Davidson County

| HEALTH REIMBURSEMENT ARRANGEMENT | | |
|---|---|---|
| | **Individual** | **Family** |
| ***Employer Contribution*** | | |
| *Pensioner without Medicare Parts A and B* | $1,100 | $2,200 |
| *Pensioner with Medicare Parts A and B* | $0 | $0 |
| **KEY BENEFIT INFORMATION** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| ***Calendar Year Combined Medical and Pharmacy Deductible –Collective*** | | |
| *Individual (employee only; no covered dependents)* | $400 | $400 |
| *Family Maximum (employee + family)* | $800 | $800 |
| ***Family Deductible - Collective**: All family members contribute towards the family deductible. An individual cannot have claims covered under the plan coinsurance until the total family deductible has been satisfied.* | | |
| ***Calendar Year Medical and Pharmacy Out-of-Pocket Maximum – Collective*** | | |
| *Individual (employee only; no covered dependents)* | $1,000 | $5,000 |
| *Family Maximum (employee + family)* | $2,000 | $10,000 |
| ***Family Out-of-Pocket Maximum - Collective**: All family members contribute towards the family out-of-pocket maximum. An individual cannot have claims covered at 100% until the total family out-of-pocket maximum has been satisfied.* | | |
| ***Coinsurance*** | CIGNA HealthCare pays 90% of eligible charges. You pay 10% of charges after plan deductible. | CIGNA HealthCare pays 70% of eligible charges. You pay 30% of charges after plan deductible. |
| ***Inpatient Preadmission Certification-CSR – PHS*** *(required for all inpatient admissions)* | Coordinated by your physician | Participant must obtain approval for inpatient admission; subject to penalty/reduction or denial for non-compliance. |
| ***Lifetime Maximum (with combined Medical and Pharmacy deductible and out-of-pocket maximum)*** ***Note**: the plan's lifetime maximum will also be combined for medical and pharmacy.* | Unlimited | $1,000,000# |
| ***Pre-existing Condition Limitation*** | No | No |
| **BENEFIT HIGHLIGHTS** | **IN-NETWORK** | **OUT-OF-NETWORK** |
| ***Physician Services*** | | |
| ***Primary Care Physician (PCP) Office Visit*** | 10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed. | 30% of charges** |
| ***Specialty Physician Office Visit*** *Consultant and Referral Physician Services* | 10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed. | 30% of charges** |
| *Allergy Treatment/Injections - PCP or Specialty Physician* | 10% of charges* | 30% of charges** |
| *Allergy Serum (dispensed by physician in office)* | 10% of charges* | 30% of charges** |
| *Second Opinion Consultations (provided on voluntary basis)* | 10% of charges* | 30% of charges** |
| *Surgery Performed in the Physician's Office- PCP or Specialty Physician* | 10% of charges* | 30% of charges** |
| ***Preventive Care*** | | |
| *Routine Preventive Care – Well Baby Care, Well Child Care and Adult Preventive Care* Unlimited maximum per calendar year | No charge, no plan deductible; No charge, no plan deductible, for x-ray and/or lab services when billed by a separate outpatient diagnostic facility. | 30% of charges** |
| ***Immunizations*** | No charge, no plan deductible | 30% of charges** |
| ***Mammograms, PSA, Pap Test*** | No charge, no plan deductible | 30% of charges** |
| ***Inpatient Hospital Services including**:* *Semi-Private Room and Board* *Diagnostic/Therapeutic Lab and X-ray* *Drugs and Medication* *Operating and Recovery Room* *Radiation Therapy and Chemotherapy* *Anesthesia and Inhalation Therapy* *MRIs, MRAs, CAT Scans, PET Scans, etc* | 10% of charges* per admission | 30% of charges* per admission<br>Precertification required |
| ***Inpatient Hospital Doctor's Visits/Consultations*** | 10% of charges* | 30% of charges** |
| ***Inpatient Hospital Professional Services*** | 10% of charges* | 30% of charges** |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Outpatient Facility Services includes**:*<br>*Operating Room, Recovery Room, Procedure Room and Treatment Room and Observation Room including:*<br>*Diagnostic/Therapeutic Lab and X-rays*<br>*Anesthesia and Inhalation Therapy*<br>*Physician & Outpatient Professional Services* | 10% of charges* per facility visit<br><br>10% of charges* | 30% of charges**<br><br>30% of charges** |
| ***Laboratory and Radiology Services (includes preadmission testing)***<br>*Physician's Office*<br>*Outpatient Hospital Facility*<br>*Emergency Room/Urgent Care Facility (billed by facility as part of the Emergency Room/Urgent Care visit)*<br>*Independent X-Ray and/or Lab Facility*<br>*Independent X-Ray and/or Lab Facility (in conjunction with an Emergency Room visit)* | <br>10% of charges*<br>10% of charges*<br>10% of charges*<br><br>10% of charges*<br>10% of charges* | <br>30% of charges**<br>30% of charges**<br>10% of charges*; *except if not a true emergency, then 30% of charges***<br><br>30% of charges**<br>10% of charges*; *if not a true emergency, then 30% of charges***|
| ***Advanced Radiological Imaging***<br>*(MRIs, MRAs, CAT Scans, PET Scans, etc.)*<br>*Outpatient Facility*<br><br>*Emergency Room (billed by facility as part of the Emergency Room visit)*<br><br>*Physician's Office* | <br>10% of charges*<br><br>10% of charges*<br><br>10% of charges* | <br>30% of charges**<br><br>10% of charges*; *except if not a true emergency, then 30% of charges***<br><br>30% of charges** |
| ***Short-Term Rehabilitative Therapy--(includes physical, speech, occupational, pulmonary rehab & cognitive therapy)***<br>Unlimited days maximum per calendar year for all therapies combined<br><br>***Note**: therapy sessions provided as part of Home Health Care accumulate to the Short-Term Rehab Therapy maximum.*<br><br>***Outpatient Cardiac Rehabilitation***<br>up to 36 days maximum per calendar year# | 10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed<br><br>10% of charges* | 30% of charges**<br><br>30% of charges** |
| ***Chiropractic Care***<br>$2,000 maximum per calendar year# | 30% of charges*; 30% of charges* if only x-ray and/or lab services are performed and billed | 50% of charges** |
| ***Emergency and Urgent Care Services***<br>*Physician's Office – PCP or Specialty Physician*<br><br>*Hospital Emergency Room*<br><br>*Outpatient Professional Services (Radiology, Pathology and Emergency Room Physician)*<br><br>*Urgent Care Facility or Outpatient Facility*<br><br>*Ambulance* | <br>10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed.<br><br>10% of charges* per visit<br><br>10% of charges* per visit<br><br>10% of charges*<br><br>10% of charges* | *Care will be provided at in-network levels if it meets the "prudent layperson" definition of an emergency. Otherwise 30% of charges***|

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Maternity Care Services*** | | |
| *Initial Office Visit to Confirm Pregnancy* | 10% of charges* for initial office visit; 10% of charges* if only x-ray and/or lab services are performed and billed | 30% of charges** |
| *All subsequent Prenatal Visits, Postnatal Visits and Physician's Delivery Charges (total maternity fee)* | 10% of charges* | 30% of charges** |
| *Office Visits not included in the total maternity fee performed by OB or Specialty Physician* | 10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed | 30% of charges** |
| *Delivery - Facility (Inpatient Hospital/Birthing Center Charges)* | 10% of charges* | 30% of charges*, precertification required |
| ***Inpatient Services at Other Health Care Facilities*** *Skilled Nursing, Rehabilitation and Sub-Acute Facilities* 100 days maximum per calendar year# | 10% of charges* | 30% of charges** |
| ***Home Health Services*** — *Includes outpatient private duty nursing when approved as medically necessary* Unlimited days maximum per calendar year; 16 hour maximum per day# | 10% of charges* | 30% of charges** |
| ***Family Planning Services*** | | |
| *Office Visits (tests, counseling)* | 10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed | 30% of charges** |
| ***Vasectomy/Tubal Ligation (excludes reversals)*** | . | |
| *Inpatient Facility* | 10% of charges* | 30% of charges*, precertification required |
| *Outpatient Facility* | 10% of charges* | 30% of charges** |
| *Physician's Services – Inpatient or Outpatient* | 10% of charges* | 30% of charges** |
| *Physician's Office* | 10% of charges*; 10% of charges* if only x-ray and/or lab services are performed and billed | 30% of charges** |
| ***Infertility Services*** *Note: Coverage will be provided for the treatment of an underlying medical condition up to the point an infertility condition is diagnosed. Services will be covered as any other illness* | Not covered | Not covered |
| ***TMJ - Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.*** | | |
| *Physician's Office* | 10% of charges*; 10% of charges* if only x-ray and/or lab services performed and billed | 30% of charges** |
| *Inpatient Facility* | 10% of charges* | 30% of charges**, precertification required |
| *Outpatient Facility* | 10% of charges* | 30% of charges** |
| *Physician's Services - Inpatient or Outpatient* *$2,000 maximum per calendar year#,* *$4,000 lifetime maximum#* | 10% of charges* | 30% of charges** |
| ***TMJ - Non-Surgical-case-by-case basis. Always excludes appliances & orthodontic treatment. Subject to medical necessity.*** | | |
| *Physician's Office* | 10% of charges*; 10% of charges* if only x-ray and/or lab services performed and billed | 50% of charges** |
| *Inpatient Facility* | 30% of charges* | 50% of charges**, precertification required |
| *Outpatient Facility* | 30% of charges* | 50% of charges** |
| *Physician's Services - Inpatient or Outpatient* *$2,000 maximum per calendar year#,* *$4,000 lifetime maximum#* | 30% of charges* | 50% of charges** |
| ***Bariatric Surgery (must meet medical necessity and clinical guidelines)*** | | |
| *Physician's Office* | 10% of charges*; 10% of charges* if only x-ray and/or lab services performed and billed | Covered in-network only |
| *Inpatient Facility* | 10% of charges* | Covered in-network only |
| *Outpatient Facility* | 10% of charges* | Covered in-network only |
| *Physician's Services - Inpatient or Outpatient* | 10% of charges* | Covered in-network only |

| BENEFIT HIGHLIGHTS | IN-NETWORK | OUT-OF-NETWORK |
|---|---|---|
| ***Mental Health***<br>***Inpatient*** - Unlimited days maximum per calendar year | 10% of charges* | 30% of charges*, precertification required |
| ***Outpatient Mental Health (includes Individual, Group Therapy and Intensive Outpatient services)***<br>Unlimited visits maximum per calendar year<br>*Physician's Office*<br>*Outpatient Facility* - | <br><br>10% of charges*<br>10% of charges* | <br><br>30% of charges**<br>30% of charges** |
| ***Substance Abuse***<br>***Inpatient*** - Unlimited days maximum per calendar year | 10% of charges* | 30% of charges*, precertification required |
| ***Outpatient Mental Health (includes Individual and Intensive Outpatient services)***<br>Unlimited visits maximum per calendar year<br>*Physician's Office*<br>*Outpatient Facility* - | <br><br>10% of charges*<br>10% of charges* | <br><br>30% of charges**<br>30% of charges** |
| ***Durable Medical Equipment***<br>Unlimited maximum per calendar year | 10% of charges* | 30% of charges** |
| ***External Prosthetic Appliances***<br>Unlimited maximum per calendar year | 10% of charges* | 30% of charges** |
| ***Acupuncture***<br>$1,000 maximum per calendar year# | 30% of charges* | 50% of charges** |
| ***Prescription Drugs-***<br>***(Includes: prescription smoking cessation products; prescription diet drugs; oral contraceptives and contraceptive devices; lifestyle drugs)***<br><br>***CIGNA Pharmacy Retail Drug Program***<br>*Generic*** drugs on the Prescription Drug List for a 102-day supply*<br><br>*Brand Name*** drugs designated as preferred and non-preferred on the Prescription Drug List for a 102-day supply*<br><br>***CIGNA Tel-Drug Mail Order Drug Program***<br>*Generic*** drugs on the Prescription Drug List for a 102-day supply*<br><br>*Brand Name*** drugs designated as preferred and non-preferred on the Prescription Drug List for a 102-day supply*<br><br>****Designated as per generally-accepted industry sources and adopted by CG* | <br><br><br><br><br>10% of charges after plan deductible per prescription/refill<br><br>30% of charges after plan deductible per prescription/refill<br><br><br>10% of charges after plan deductible per prescription/refill<br><br>30% of charges after plan deductible per prescription/refill | <br><br><br><br><br>30% of charges after plan deductible per prescription/refill<br><br>30% of charges after plan deductible per prescription/refill<br><br><br>Covered in-network only<br><br>Covered in-network only |

**** Services are subject to calendar year deductible***

***** Out-of-network services are subject to calendar year deductible and maximum reimbursable charge limitations. Providers may bill the member the difference between their billed charge and the maximum reimbursable charge as determined by the benefit plan.***

***# In-network and out-of-network services apply to the same treatment or dollar maximum.***

***Footnotes:***

***Regarding In-Network and Out-of-Network Services:***

- *Once the plan's out-of-pocket maximum is reached, the plan pays 100% of eligible charges for the remainder of the plan year.*

***Regarding In-Network Services:***

- *All services must be provided by one of the participating providers on our list in order to be covered.*

***Regarding Out-of-Network Services:***

- *Your out-of-pocket costs will be higher than with a participating provider.*
- *All inpatient hospital admissions require Preadmission Certification and Continued Stay Review. Failure to obtain Preadmission Certification and/or Continued Stay Review may result in non-compliance penalties and/or reduction of benefits. Call the toll-free number on your CIGNA HealthCare ID Card.*

## Case Management

Coordinated by CIGNA HealthCare. This is a service designed to provide assistance to a patient who is at risk of developing medical complexities or for whom a health incident has precipitated a need for rehabilitation or additional health care support. The program strives to attain a balance between quality and cost effective care while maximizing the patient's quality of life.

## Benefit Exclusions.

These are examples of the exclusions in your plan. The complete list of exclusions is provided in your Certificate or Summary Plan Description. To the extent there may be differences, the terms of the Certificate or Summary Plan Description control.

1. Any service or supply not described as covered in the Covered Expenses section of the plan.
2. Any medical service or device that is not medically necessary.
3. Treatment of an illness or injury which is due to war or care for military service disabilities treatable through governmental services.
4. Any services and supplies for or in connection with experimental, investigational or unproven services.
5. Dental treatment of the teeth, gums or structures directly supporting the teeth, however, charges made for services or supplies provided for or in connection with an accidental injury to sound natural teeth are covered provided a continuous course of dental treatment is started within 6 months of the accident.
6. Medical and surgical services, initial and repeat, intended for the treatment or control of obesity. However, treatment of clinically severe obesity, as defined by the body mass index (BMI) classifications of the National Heart, Lung and Blood Institute (NHLBI) guideline is covered only at approved centers if the services are demonstrated, through existing peer-reviewed, evidence-based, scientific literature and scientifically based guidelines, to be safe and effective for treatment of the condition. Clinically severe obesity is defined by the NHLBI as a BMI of 40 or greater without comorbidities, or 35–39 with comorbidities. The following are specifically excluded: medical and surgical services to alter appearances or physical changes that are the result of any surgery performed for the management of obesity or clinically severe (morbid) obesity; and weight loss programs or treatments, whether prescribed or recommended by a physician or under medical supervision
7. Unless otherwise covered as a basic benefit, reports, evaluations, physical examinations, or hospitalization not required for health reasons, including but not limited to employment, insurance or government licenses, and court ordered, forensic, or custodial evaluations.
8. Court ordered treatment or hospitalizations.
9. Infertility services, infertility drugs, surgical or medical treatment programs for infertility, including in vitro fertilization, gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT), variations of these procedures, and any costs associated with the collection, washing, preparation or storage of sperm for artificial insemination (including donor fees). Cryopreservation of donor sperm and eggs are also excluded from coverage.
10. Medical and hospital care and costs for the child of a Dependent, unless this infant child is otherwise eligible under the plan.
11. Therapy or treatment intended primarily to improve or maintain general physical condition or for the purpose of enhancing job, school, athletic or recreational performance.
12. Consumable medical supplies other than ostomy supplies and urinary catheters.
13. Private hospital rooms and/or private duty nursing except as provided under the Home Health Services provision.
14. Artificial aids, including but not limited to hearing aids, semi-implantable hearing devices, audiant bone conductors, bone anchored hearing aids, arch supports, elastic stockings, garter belts, corsets, dentures and wigs.
15. Eyeglass lenses and frames and contact lenses (except for the first pair of contact lenses for treatment of keratoconus or postcataract surgery).
16. Routine refraction, eye exercises and surgical treatment for the correction of a refractive error.
17. Non-prescription drugs and investigational and experimental drugs, except as provided in the plan.
18. Routine foot care, however, services associated with foot care for diabetes and peripheral vascular disease are covered when medically necessary.
19. Genetic screening or pre-implantation genetic screening.

**Benefit Exclusions continued:**

20. Fees associated with the collection or donation of blood or blood products.
21. Cost of biologicals that are immunizations or medications for the purpose of travel, or to protect against occupational hazards and risks.
22. All nutritional supplements and formulae are excluded, except infant formula needed for the treatment of inborn errors of metabolism.
23. Services for or in connection with an injury or illness arising out of, or in the course of, any employment for wage or profit.
24. Expenses incurred for medical treatment by a person age 65 or older, who is covered under the plan as a retiree, or his dependent, when payment is denied by the Medicare plan because treatment was not received from a participating provider of the Medicare plan.
25. Expenses incurred for medical treatment when payment is denied by the primary plan because treatment was not received from a participating provider of the primary plan.
26. The following services are excluded from coverage regardless of clinical indications: Massage Therapy; Cosmetic Surgery and Therapies; Craniosacral/cranial therapy; Dance Therapy, Movement Therapy; Applied Kinesiology; Rolfing; Prolotherapy; Transsexual Surgery; Non-medical counseling or ancillary services; Assistance in the activities of daily living; Cosmetics; Personal or Comfort Items; Dietary Supplements; Health and Beauty Aids; Aids or devices that assist with non-verbal communications; Dental implants for any condition; Telephone Consultations; E-mail & Internet Consultations; Telemedicine; Health Club Membership fees; Weight Loss Program fees; Smoking Cessation Program fees; Reversal of male and female voluntary sterilization procedures; and Extracorporeal Shock Wave Lithotripsy for musculoskeletal and orthopedic conditions.

## These Are Only the Highlights

*As you can see, the plan is designed to combine in-depth coverage with affordable prices. This summary contains highlights only and is subject to change. The specific terms of coverage, exclusions and limitations including legislated benefits are contained in the Summary Plan Description or Insurance Certificate. This plan is insured and/or administered by Connecticut General Life Insurance Company, a CIGNA Company.*

*"CIGNA HealthCare" refers to various operating subsidiaries of CIGNA Corporation. Products and services are provided by these subsidiaries and not by CIGNA Corporation. These subsidiaries include Connecticut General Life Insurance Company, Tel-Drug, Inc. and its affiliates, CIGNA Behavioral Health, Inc., Intracorp, and HMO or service company subsidiaries of CIGNA Health Corporation and CIGNA Dental Health, Inc.*

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